Alameda County HMIS Intake Form v2020.1

First: ________________ Middle: ________ Unique Identifier: [ ][ ][ ][ ][ ][ ][ ][ ][ ]

Last: ________________ Suffix: ______

Project Name:__________________ **Project Start Date:** [ ][ ]/[ ][ ]/[ ][ ]

Relationship to Head of Household:	☐ Self (head of household)	☐ Head of household's child
☐ Head of household's spouse or partner	☐ Head of household's other relation member	☐ Head of household's non-relation member

If Street Outreach Complete date of Engagement when Client has been Engaged: __ __/ __ __/ __ __

In permanent housing?: Move-in date: ** __ __/ __ __/ __ __ *****Enter housing move in date on ENROLLMENT screen*****

Type of Residence: ***(Where did you stay last night?) (Select ONE)***

Homeless Situation	Transitional and Permanent Housing	
☐ Place not meant for habitation (e.g. vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter ☐ Safe Haven	☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Transitional housing for homeless persons (including homeless youth) ☐ Host Home (non-crisis) ☐ Staying or living in a FRIEND'S room, apartment or house ☐ Staying or living in a FAMILY member's room, apartment or house ☐ Rental by client, with GPD TIP housing subsidy ☐ Rental by client, with VASH housing subsidy	☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy

Institutional Situation		Unknown
☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility	☐ Long-term care facility or nursing home ☐ Psychiatric hospital of other psychiatric facility ☐ Substance abuse treatment facility or detox center	☐ Client doesn't know ☐ Client refused

Length of Stay in Prior Living Situation:			
☐ One night or less	☐ Two to six nights	☐ One week or more, but less than one month	☐ One month or more, but less than 90 days
☐ 90 days or more, but less than one year	☐ One year or longer	☐ Client doesn't know	☐ Client refused

Length of Stay Less Than 7 Nights	☐ No	☐ Yes
Length of Stay Less Than 90 Days	☐ No	☐ Yes
On the Night Before—Stayed on the streets, ES or Safe Haven	☐ No	☐ Yes

Approximate date homelessness started: __ __/ __ __/ __ __ __ __

Number of times on the street, in ES, or Safe Haven in the past three years:

☐ One time ☐ Two times ☐ Three times ☐ Four or more times ☐ Client doesn't know ☐ Client refused

Total number of months homeless on the street, in emergency shelter or SH in the past three years ________

Domestic Violence

Are you, or have you been a survivor of domestic or intimate partner violence?	If **YES**, how long ago did you have this experience?	If **YES** , are you currently fleeing ?
☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ Within the past 3 months ☐ 3 to 6 months ago ☐ 6 months to 1 year ago ☐ 1 year ago or more ☐ Client doesn't know ☐ Client refused	☐ No ☐ Client doesn't know ☐ Yes ☐ Client refused

Disability: ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused	☐ Physical	☐ Mental Health	☐ Chronic Health Condition	☐ Alcohol ☐ Drugs ☐ Both	☐ Developmental	☐ HIV/AIDS
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes	☐ Yes

Alameda County HMIS Intake Form v2020.1

Cash Income for Individual

Income from Any Source?

- ☐ No/None at all
- ☐ **Yes** (identify source and amounts)
- ☐ Client doesn't know
- ☐ Client refused

Source:	**Amount:**
☐ Earned income **(i.e., employment income)**	$ __ __ __ __ . 00
☐ Unemployment Insurance	$ __ __ __ __ . 00
☐ Worker's Compensation	$ __ __ __ __ . 00
☐ Private disability Insurance	$ __ __ __ __ . 00
☐ VA Service-Connected Disability Compensation	$ __ __ __ __ . 00
☐ Social Security Disability Insurance **(SSDI)**	$ __ __ __ __ . 00
☐ Supplemental Security Income **(SSI)**	$ __ __ __ __ . 00
☐ Retirement Income from Social Security	$ __ __ __ __ . 00
☐ VA Non-Service-Connected Disability Pension	$ __ __ __ __ . 00
☐ Pension or retirement income from a former job	$ __ __ __ __ . 00
☐ Temporary Assistance for Needy Families **(TANF)**	$ __ __ __ __ . 00
☐ General Assistance **(GA)**	$ __ __ __ __ . 00
☐ Alimony or other spousal support	$ __ __ __ __ . 00
☐ Child Support	$ __ __ __ __ . 00
☐ Other Cash Income	$ __ __ __ __ . 00
Other Cash Income Source: ___________________________	
Total Cash Income for Individual :	$

Non-Cash Benefits

Receiving Non-Cash Benefits?

- ☐ No/None at all
- ☐ **Yes** (identify source)
- ☐ Client doesn't know
- ☐ Client refused

- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Special Supplemental, Nutrition Program for Women, Infants, and Children
- ☐ TANF Child Care services
- ☐ TANF Transportation services
- ☐ Other TANF-Funded services
- ☐ Other Non–Cash Benefit Source: ___________________________

Health Insurance

Covered by Health Insurance?

- ☐ **Yes** (identify source)
- ☐ No
- ☐ Client doesn't know
- ☐ Client refused

- ☐ MEDICAID/Medi-Cal
- ☐ MEDICARE
- ☐ State Children's Health Insurance
- ☐ Veteran's Administration (VA) Medical Services
- ☐ Employer-Provided Health Insurance
- ☐ Health Insurance obtained through COBRA
- ☐ Private Pay Health Insurance
- ☐ State Health Insurance for Adults
- ☐ Indian Health Services Program
- ☐ Other Health Insurance Source: ____________________

Staff Completing (Printed Name):	**Date:**